Public Health – Seattle & King County
Client Registration Information

Please Print

Please complete this registration form and return it to the check-in desk. The information on this form is considered private and will not be shared except for the provision, support, and billing of your health care services.

Name: _____
Last First Middle Initial Maiden/Other Last Name

Date of Birth: ____/____/____ **Sex**: ☐ Male ☐ Female
Month Day Year

Home Phone: (____) _____ **Work Phone:** (____) _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Have you ever been seen at our clinic before: ❒ Yes ❒ No When? _____

Please tell us about your CURRENT living situation.	
Last night, where did you sleep? (check one):	❒ A shelter (9930311)
❒ Your own home/apartment No Code	❒ On the street or other public area (9930306)
❒ Transitional housing (longer term shelter/housing) (9930313)	❒ At a friend's or with family because you had nowhere else to go (9930323)
❒ Jail, hospital, or other treatment facility (9930335)	❒ Other _____ (9930319)

Within the LAST YEAR, have you slept at any of these locations (other than your own home or apartment or in a motel) because you had nowhere else to go) or in foster care? YES ❒ NO ❒ (9930335)

Are you of Hispanic/Latino heritage?	☐ Yes	☐ No	☐ Decline to answer

Race (Please check **all** that apply):					
☐ Asian (A)	☐ Black or (B) African American	☐ Native American (N) or Alaska Native	☐ Pacific Islander or (P) Hawaiian Native	☐ White (W)	☐ Decline to (U) answer

Have you ever served in the U.S. Military?	☐ Yes	☐ No	☐ Decline to answer

Do you need an interpreter?	☐ Yes	☐ No	**If Yes, Primary Language:**	

Financial Information (*This information will be used to calculate discounted fees)*
NO PERSON WILL BE DENIED SERVICE BECAUSE OF INABILITY TO PAY.

Total Household Income - Please include all sources before taxes, including: Salary/Wages, DSHS/Welfare Checks, Social Security/SSI, Unemployment, Child Support, etc.	**Number of people supported on this income**
$ _____ per month $_____ per year	_____

Insurance Information

Type of Insurance	**1) Check all that apply** **2) Show your coupon or insurance card to the check-in desk**
Medical Coupons/Medicaid	☐
Medicare – Part B	☐
Basic Health Plan	☐ Name of Insurance Plan: _____
Private Insurance	☐ Name of Insurance Plan: _____
Secondary Private Insurance	☐ Name of Insurance Plan: _____

Please read and sign below:

Release of Benefits and Information: I authorize my insurance benefits to be paid directly to the medical provider. I am financially responsible for any balance due. I authorize the medical provider or Insurance Company to release any information required for this claim. I certify that the above information is accurate, to the best of my knowledge.

Consent for Treatment: I hereby grant permission to the STD Clinic at Harborview Medical Center, a contractor of Public Health-Seattle & King County, to perform such medical and therapeutic procedures as may be professionally deemed necessary or advisable for my diagnosis and treatment. I understand my lab sample may be stored and re-tested to check the quality of our lab methods.

Signature _____ Date _____ ☐ Patient ☐Parent ☐Guardian

OFFICE USE ONLY						
❒ New ❒ Update ❒ Make	HR ID# (Pt ID# if no chart) :					
Clerk Initials	Pay Status:	**A**	**B**	**C**	**D**	**E**